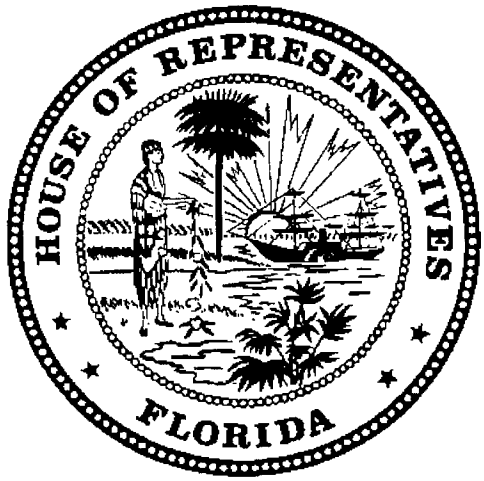

Elder and Long Term Care Committee

Tuesday, April 4, 2006
10:30 AM – 11:00 AM
Reed Hall (102 HOB)

Meeting Packet

Allan Bense
Speaker

Hugh Gibson, III
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Elder & Long-Term Care Committee

Start Date and Time:	Tuesday, April 04, 2006 10:30 am
End Date and Time:	Tuesday, April 04, 2006 11:00 am
Location:	Reed Hall (102 HOB)
Duration:	0.50 hrs

Consideration of the following bill(s):

HB 13 CS Department of Elderly Affairs by Robaina
HB 1247 Developmental Disabilities by Kravitz
HB 1273 Home Health Services by Cusack

NOTICE FINALIZED on 03/31/2006 16:12 by MANNING.KAREN

House of Representatives

Elder and Long Term Care Committee

AGENDA

April 4, 2006
10:30 AM – 11:00 AM
Reed Hall (102 HOB)

I. Opening Remarks by the Chair

II. Consideration of the following bill(s):

HB 13 CS Department of Elder Affairs by Robaina

HB 1247 Developmental Disabilities by Kravitz

HB 1273 Home Health Services by Cusack

III. Closing Remarks by the Chair

IV. Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 13 CS Department of Elderly Affairs
SPONSOR(S): Robaina and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1330

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Governmental Operations Committee	6 Y, 0 N, w/CS	Brown	Williamson
2) Elder & Long-Term Care Committee		DePalma	Walsh
3) Health Care Appropriations Committee			
4) State Administration Council			
5)			

SUMMARY ANALYSIS

The bill provides that if the Department of Elderly Affairs takes any intermediate measures against an area agency on aging for failing to provide certain contract services, and if the area agency on aging fails to improve service delivery after at least 90 days, the Department may terminate the relevant contract(s) and re-contract for the service or provide the service directly to the affected population. The bill requires an evaluation before terminating an area agency.

Subsequent contracts must be made competitively, in accordance with Chapter 287, F.S. The Department may temporarily provide the service, but the competitive procurement process must begin within 180 days.

The Department has said there is no fiscal impact associated with the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard individual liberty – The bill provides for more immediate termination and re-bidding of poorly-operating contracts for programs delivering services to the elderly.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

The Department of Elderly Affairs (hereinafter the "Department") assists and protects the state's elderly citizens "to the fullest extent."[1] One of the primary duties of the Department is the delivery of federally-funded programs and services,[2] and the administration of "human services programs" for the elderly.[3] These programs and services are coordinated with area agencies on aging, groups organized at the regional level[4] which in turn directly contract for particular services.[5]

The Department is tasked to ensure that each area agency on aging (hereinafter "AAA" or "agency") "operates in a manner to ensure that the elderly of this state receive the best services possible."[6] The Department monitors the AAA's to ensure that none of the following problems arise:[7]

- An intentional or negligent act of the agency has materially affected the health, welfare, or safety of clients, or substantially and negatively affected the operation of an aging services program.
- The agency lacks financial stability sufficient to meet contractual obligations or that contractual funds have been misappropriated.
- The agency has committed multiple or repeated violations of legal and regulatory requirements or department standards.
- The agency has failed to continue the provision or expansion of services after the declaration of a state of emergency.
- The agency has exceeded its authority or otherwise failed to adhere to the terms of its contract with the department or has exceeded its authority or otherwise failed to adhere to the provisions specifically provided by statute or rule adopted by the department.
- The agency has failed to properly determine client eligibility as defined by the department or efficiently manage program budgets.
- The agency has failed to implement and maintain a department-approved client grievance resolution procedure.

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[1] Section 430.02(1), F.S.
[2] Section 430.02(2), F.S.
[3] Section 430.03(1), F.S.
[4] The State of Florida is currently divided into 11 Planning and Service Areas, according to the *2005 Annual Report Summarizing DOEA's Monitoring Activities of Area Agencies on Aging* (hereinafter the "*2005 Annual Report*").
[5] *2005 Annual Report,* p. 1
[6] Section 430.04(2), F.S.
[7] Section 430.04(2)(a) – (f), F.S.

In the event any of these problems occur, the Department may rescind an AAA's official status or take intermediate measures including:[8]

- Corrective actions,
- Unannounced special monitoring,
- Temporary assumption of operations,
- Placement on probationary status,
- Moratorium on agency action,
- Financial penalties for non-performance, or
- Other administrative action pursuant to chapter 120, F.S.

Proposed Changes

The bill modifies s. 430.04(2), F.S., to provide that administrative action pursuant to chapter 120, F.S., can be taken only after an evaluation.

The bill also provides that, in the event the Department takes any "intermediate measures" against an AAA for services not funded under the federal Older Americans Act,[9] and the AAA fails to improve service delivery after at least 90 days, the Department may terminate the relevant contract(s) and re-contract for the service or provide the service directly to the affected population.

If the Department elects to re-contract for the service previously provided by the AAA, the subsequent contract must be made competitively, in accordance with Chapter 287, F.S.[10] The Department may provide the affected service directly, for a limited time, but the competitive procurement process must begin within 180 days of the termination of the AAA.

In addition to these safeguards, any contracts made with a service provider by the AAA after July 1, 2006 must contain an assignment clause allowing the Department or another designee to become the assignee of the contract, in order to ensure continuity of service.

C. SECTION DIRECTORY:

Section 1. Amends s. 430.04, F.S., to require an evaluation before the Department can take action against an area agency on aging; to permit the Department to terminate contracts and provide for alternative methods of service delivery under certain circumstances; and require assignment clauses in future contracts between AAAs and service providers.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not create, modify, amend, or eliminate a state revenue source.

2. Expenditures:

   The bill does not create, modify, amend, or eliminate a state expenditure.

[8] Section 430.04(2), F.S.
[9] Services "not funded under the federal Older Americans Act" refers to services funded through the state's General Revenue Fund.
[10] Generally speaking, chapter 287, F.S., mandates competitive open bidding for all commodities and services purchased by agencies.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The bill does not create, modify, amend, or eliminate a local revenue source.

2. Expenditures:

The bill does not create, modify, amend, or eliminate a local expenditure.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DOEA already seems to possess authority under current state law to discipline and sanction AAAs violating federal or state statutes, rules and policies. Under s. 430.04(2), F.S., in addition to the range of "intermediate measures" which the department may pursue against an AAA, the department is authorized to rescind the designation of an area agency on aging in certain situations. Similarly, Rule 58A-1.006(6), F.A.C., provides that the department shall withhold distribution of a portion of the contract funds designated for an AAA in proportion to the amount of services not furnished by the AAA.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 29, 2006, the Governmental Operations Committee adopted a proposed committee substitute and reported the bill favorably with committee substitute. The bill completely overhauled chapter 430, F.S. The committee substitute limited the changes to:

- Provide that the Department may take intermediate measures against an AAA after an evaluation;
- Provide that the Department may terminate a contract with an AAA under certain circumstances;
- Provide that re-procurement of services must be made in accordance with chapter 287, F.S., and must begin within 180 days of termination; and
- Require assignment clauses in future contracts between AAA's and service providers.

CHAMBER ACTION

The Governmental Operations Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to the Department of Elderly Affairs; amending s. 430.04, F.S.; requiring the Department of Elderly Affairs to conduct an evaluation prior to rescinding designation of or taking certain measures against an area agency on aging; providing circumstances under which the department may terminate an area agency on aging contract; authorizing the department to contract with certain entities to provide programs and services under certain circumstances; requiring the department to initiate a competitive procurement process to replace an area agency on aging within a specified time period; providing for certain contracts and agreements to be assignable to the department and, subsequently, to an entity selected to replace the area agency on aging; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (2) of section 430.04, Florida Statutes, is amended, subsections (3) through (16) are renumbered as subsections (4) through (17), respectively, and a new subsection (3) is added to that section, to read:

430.04 Duties and responsibilities of the Department of Elderly Affairs.--The Department of Elderly Affairs shall:

(2) Be responsible for ensuring that each area agency on aging operates in a manner to ensure that the elderly of this state receive the best services possible. The department shall rescind designation of an area agency on aging or take intermediate measures against the agency, including corrective action, unannounced special monitoring, temporary assumption of operation of one or more programs by the department, placement on probationary status, imposing a moratorium on agency action, imposing financial penalties for nonperformance, or other administrative action pursuant to chapter 120, if, after an evaluation, the department finds that:

(a) An intentional or negligent act of the agency has materially affected the health, welfare, or safety of clients, or substantially and negatively affected the operation of an aging services program;~~.~~

(b) The agency lacks financial stability sufficient to meet contractual obligations or that contractual funds have been misappropriated;~~.~~

(c) The agency has committed multiple or repeated violations of legal and regulatory requirements or department standards;~~.~~

(d) The agency has failed to continue the provision or expansion of services after the declaration of a state of emergency;~~.~~

(e) The agency has exceeded its authority or otherwise failed to adhere to the terms of its contract with the department or has exceeded its authority or otherwise failed to adhere to the provisions specifically provided by statute or rule adopted by the department;~~.~~

(f) The agency has failed to properly determine client eligibility as defined by the department or efficiently manage program budgets; or~~.~~

(g) The agency has failed to implement and maintain a department-approved client grievance resolution procedure.

(3) If the department takes an intermediate measure against an area agency on aging as provided in subsection (2) and the department determines, at least 90 days after such measure is taken, that the agency has failed to effectively plan, fund, or administer contracts for programs and services not funded by the federal Older Americans Act, the department may terminate an agency's contract for such programs or services. Notwithstanding any law to the contrary, in the event of the termination of a contract with an agency, the department shall contract, in accordance with chapter 287, with an entity to plan, fund, and administer the programs and services previously under contract in the affected planning and service area. The department may directly provide the affected program or service for a limited period of time but shall initiate a competitive procurement process to replace the agency within 180

days after the termination of the agency's contract. Any contract or referral agreement effective on or after July 1, 2006, between an area agency on aging and a lead agency or service provider must be assignable to the department and subsequently to an entity competitively selected under this subsection.

Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1247 Developmental Disabilities
SPONSOR(S): Kravitz
TIED BILLS: **IDEN./SIM. BILLS:** SB 2226

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee		DePalma	Walsh
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1247 amends section 409.912, F.S., and requires the Agency for Health Care Administration to work with the Agency for Persons with Disabilities to develop and seek federal approval to expand the statutorily-required home and community-based waiver serving children who are diagnosed with Familial Dysautonomia to include adults. The bill also amends the nature of this waiver by deleting a requirement that the agencies seek approval for a "model" waiver.

The bill appropriates $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund for the purpose of implementing the act during State Fiscal Year 2006-07.

The bill provides that the act is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates Medicaid eligibility for a new group of individuals.

Empower Families – The bill increases dependence of families upon government support and assistance.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Familial Dysautonomia Syndrome

Familial Dysautonomia (FD) --- or Riley-Day Syndrome --- is an example of a group of disorders known as "hereditary sensory and autonomic neuropathies" (HSAN) characterized by widespread sensory dysfunction resulting from incomplete development of sensory and autonomic neurons.[1] First identified in a report by Drs. Conrad Riley and Richard Day in 1949, FD is a debilitating disease that is present from birth, and results in lifelong progressive neuronal degeneration.[2]

Prior to 1960, approximately 50% of patients suffering from FD died before reaching the age of five.[3] However, recent advances in supportive treatment approaches have extended the life expectancy of individuals with FD, and the probability of reaching age 20 has now increased to 60%,[4] and roughly half of patients diagnosed with FD live to the age of 30.

Transmission

Unlike other HSAN, Familial Dysautonomia has been observed only in individuals of Eastern European Jewish Ancestry (Ashkenazi Jewish extraction), and it is estimated that one in 27 individuals of Eastern European Jewish origin are carriers of the FD gene.[5] The Dysautonomia Foundation, Inc. in New York reports that, based on information available from the FD world-wide registry, as of January 2004 there were over 340 people worldwide living with FD. One-third of these individuals live in the metropolitan New York City area, one-third reside in Israel, and the remaining third live elsewhere in the United States and worldwide.[6] It has been reported by the Agency for Health Care Administration (AHCA) that 18 persons with FD (**10 children and 8 adults**) are residents of Florida.

Familial Dysautonomia is an autosomal recessive disorder[7], meaning that a child must inherit a copy of the FD gene from each of their birth parents. All parents of children with Familial Dysautonomia are

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[1] *More About FD*, 2005, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation Center, available at: http://www.med.nyu.edu/fd/fdcenter.html.
[2] *Familial Dysautonomia*, January 10, 2005, report by GeneTest (funded by the National Institutes of Health), available at: http://www.genetests.org/profiles/fd.
[3] *Familial Dysautonomia (FD)*, accessed March 9, 2006, Jewish Genetic Diseases: A Mazornet Guide, available at: http://www.mazornet.com/genetics/familial_dysautonomia.asp.
[4] *Ibid.*
[5] *FD 101: What is FD?*, accessed March 6, 2006, Familial Dysautonomia Hope Foundation, available at: http://www.fdhope.org/FamilialDysautonomia/AboutFD/FD101.htm.
[6] *FD History and Statistics*, accessed March 6, 2006, the Dysautonomia Foundation, Inc., available at: http://www.familialdysautonomia.org/history.htm.
[7] *About Familial Dysautonomia: Genetics*, accessed March 6, 2006, Familial Dysautonomia Hope Foundation, available at: http://www.fdhope.org/FamilialDysautonomia/AboutFD/genetics.htm.

carriers of the recessive gene that transmits the disease, although a parent or carrier of the gene has no symptoms or warning signs of being a carrier until a child's birth.[8]

Symptoms

Familial Dysautonomia primarily affects the body's autonomic nervous system (responsible for the subconscious regulation of bodily functions and the activities of specific organs) and its sensory nervous system (which controls the body's perceptions of hot/cold and taste, and regulates its protective reactions to pain and other external stimuli).[9]

Although symptoms vary with age, the hallmark clinical feature of Familial Dysautonomia is the absence of overflow tears typically associated with emotional crying.[10] Corneal sensitivity and various other severe eye problems occur frequently in FD patients as a result.

Feeding difficultly is observed in 60% of infants with FD in the neonatal period, and poor suck and misdirected swallows often persist and put the patient at risk for aspiration pneumonia (a major cause of lung infections). Other clinical manifestations of the disorder include: decreased responsiveness to pain and temperature, extreme fluctuations in blood pressure, red blotching of the skin, and increased sweating. Additionally, individuals suffering from Familial Dysautonomia often have delayed acquisition of speech and walking abilities, unsteady gait, breath-holding episodes and poor growth patterns. By age 13, 90% of FD patients experience some spinal curvature.[11]

Familial Dysautonomia patients can be expected to function independently if treatment is begun early and major disabilities are avoided. Affected individuals typically are of normal intelligence.

Dysautonomia Crisis

Roughly 40% of individuals with FD will react to stressors or stress events (frequently caused by physical infection or emotional events) with what is termed a "dysautonomia crisis." In addition to vomiting, an individual having a dysautonomia crisis experiences elevated heart rate and blood pressure, irritability and insomnia, severe dysphagia and drooling, and excessive sweating and blotching of the face and trunk.[12]

Treatment

As there is still no cure for Familial Dysautonomia, treatment approaches remain preventative, supportive, and largely symptomatic, and include:[13]

- artificial tears;
- special feeding techniques;
- special occupational, physical and speech therapies;
- special drug management of autonomic manifestations;
- respite care
- orthopedic treatment (for complications from tibial torsion and spinal curvature); and
- compensation for labile blood pressures.

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[8] *More About FD*, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation, *supra*.
[9] What is Familial Dysautonomia?, accessed March 6, 2006, the Dysautonomia Foundation, Inc., available at: http://www.familialdysautonomia.org/whatisfd.htm.
[10] *More About FD*, the NYU School of Medicine Department of Pediatrics Dysautonomia Treatment & Evaluation, *supra*, noting that, although the absence of overflow tears is the most distinctive feature of Familial Dysautonomia, it is typical for a child not to have tears until reaching 7 months of age.
[11] *Ibid.*
[12] *Ibid.*
[13] *Familial Dysautonomia (FD)*, Jewish Genetic Diseases: A Mazornet Guide, *supra*.

Funding for Familial Dysautonomia Services

The Department of Health, Children's Medical Services (CMS), currently provides services to children diagnosed with FD whose families meet certain income limitations. Under certain federal requirements of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) specifying that Medicaid programs meet children's medical needs, CMS is able to provide care coordination for a range of needed services and therapies. However, CMS does not have funding to provide families of FD children with respite or behavioral services. Persons with FD are not served by the Agency for Persons with Disabilities (APD).[14]

Medicaid Home and Community-based Waivers

In 1981, Congress authorized the waiver of certain federal requirements to enable a state to provide home and community-based services (other than room and board) to individuals who would otherwise require institutional care reimbursed by Medicaid. The waiver programs are called "1915(c) waivers." Under 1915(c) waiver authority, states can provide services not traditionally covered by the Medicaid program, as long as these services are integral to preventing an individual's institutionalization. A 1915(c) waiver may include a waiver of the requirements of the following sections of the Social Security Act:[15]

- 1902(a)(1), relating to statewideness. This allows states to target waivers to particular areas of the state where the need is greatest, or perhaps where certain types of providers are available;
- 1902(a)(10)(B), relating to comparability of services. This allows states to make waiver services available to the Medicaid population at large. States use this authority to target services to particular groups, such as elderly individuals, technology-dependent children, or persons with mental retardation or developmental disabilities; and
- 1902(a)(10)(c)(i)(III), relating to community income and resource rules for the medically needy. This allows states to provide Medicaid to individuals who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States may also use spousal impoverishment rules to determine financial eligibility or waiver services.

A 1915(c) waiver is initially authorized for three years, and renewals are required every five years thereafter. Within the parameters of broad federal guidelines, 1915(c) waiver authority provides states with flexibility in structuring home and community-based waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement a home and community-based waiver program include:

- demonstrating that provision of waiver services to a target population is no more costly than the cost of services such individuals would receive in an institutional setting;
- ensuring that measures will be taken to protect the health and welfare of consumers;
- assuring financial accountability for funds expended under the waiver authority;
- providing adequate and reasonable provider standards intended to meet the needs of the target population; and
- ensuring that services are provided in accordance with a plan of care.

[14] The Agency for Persons with Disabilities was formerly the Development Disabilities Program of the Department of Children and Families. Pursuant to s. 20.197(2), APD is charged with administering waivers established to provide services to persons with developmental disabilities. Familial Dysautonomia is not a "developmental disability" pursuant to s. 393.063(10), F.S."

[15] HCBS Waivers Section 1915(c), accessed March 29, 2006, U.S. Department of Health and Human Services Center for Medicare and Medicaid Services, available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp#TopOfPage.

Previous Legislation

Chapter 2005-115, L.O.F., enacting HB 17, directed the Agency for Health Care Administration (AHCA) to work with APD in developing a model home and community-based waiver to serve children diagnosed with FD. The legislation required AHCA to seek federal waiver approval and implement the approved waiver, subject to the availability of funds and any limitations provided in the General Appropriations Act. The act also appropriated $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund for FY 2005-06.

On March 20, 2006, AHCA submitted an application for a section 1915(c) home and community-based waiver to authorize operation of a Familial Dysautonomia Model Home and Community-Based Services Waiver. By electing to structure the waiver as a "Model" waiver,[16] federal regulations require that no more than 200 individuals are to be served by the waiver at any one time.[17]

Despite the statutory instruction to develop a model home and community-based waiver to serve children diagnosed with FD, the waiver application submitted by AHCA indicates that the waiver will serve a maximum of 20 "participants" diagnosed with FD. As noted earlier, AHCA has identified 18 persons in Florida with FD --- 10 children and 8 adults. AHCA advises that the waiver application can be amended to restrict eligibility to children should the proposed bill not be enacted.

The Department of Children and Family Services (DCF) reports that, for purposes of establishing Medicaid eligibility under the waiver, children and single adults are considered a "family of one", and only the income and assets of the child or single adult individually are considered by the department when assessing eligibility.

PROPOSED CHANGES

HB 1247 amends s. 409.912(51), F.S., to add adults as participants in the Familial Dysautonomia home and community-based waiver, and to delete a provision specifying that implementation of the waiver is "subject to the availability of funds and any limitations provided in the General Appropriations Act."

By deleting the reference to a "model" home and community-based waiver in s. 409.912(51), F.S., the bill requires that the waiver be structured as a regular home and community-based waiver pursuant to 42 C.F.R. s. 441.305(a). Therefore, the bill makes the 200-participant limited enrollment provision for "model" waivers[18] inapplicable.

The bill provides that the sums of $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund are to be appropriated to AHCA for the purpose of implementing the act during the 2006-2007 fiscal year.

The bill is effective upon becoming law.

C. SECTION DIRECTORY:

Section 1: Amends s. 409.912, F. S., adding adults diagnosed with Familial Dysautonomia to the home and community-based waiver developed by AHCA and APD; deleting a provision indicating that implementation of the waiver is subject to the availability of funds and any other limitation provided in the General Appropriations Act.

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[16] The "Model" waiver submitted by AHCA is different from the model waiver authorized under section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 134), commonly referred to as the "Katie Beckett" waiver. A waiver under this provision in TEFRA allows a state to make the full array of Medicaid services available to a disabled child irrespective of the income and assets of the child's parents. Such children are "deemed" eligible. A Katie Beckett waiver is not a means of providing Medicaid funds or services to adults.

[17] 42 C.F.R. s. 441.305(b).

[18] *Ibid.*

Section 2: Provides appropriations from the General Revenue Fund and Medical Care Trust Fund to AHCA for purposes of implementing the act.

Section 3: Provides that the bill is effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The legislation appropriates the sums of $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund to AHCA for the purpose of implementing the act during the 2006-2007 fiscal year.

   Although AHCA reports that there are presently 18 individuals in the state suffering from Familial Dysautonomia, the waiver application submitted to CMS specifies that the waiver is requested to serve a maximum of 20 potential beneficiaries. Accordingly, AHCA has calculated, as part of its waiver application, that a $418,000 appropriation serving 20 beneficiaries equates to $20,900 available for services per beneficiary.

   AHCA advises that no additional funding is necessary to administer this legislation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

AHCA reports that the bill creates no direct economic impact on the private sector.

D. FISCAL COMMENTS:

Appropriations staff reports that the funds appropriated from the General Revenue and Medical Care Trust Funds for the purpose of implementing the 2005 legislation are recurring. In this sense, the appropriations in section 2 of the current legislation would be unnecessary.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Should this legislation be enacted, it would require AHCA to amend its pending application to reflect "regular" waiver status, rather than "model."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 1247**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Elder & Long Term Care

Representative(s) Kravitz offered the following:

Amendment (with directory and title amendments)

Remove line(s) 85-89

========== T I T L E A M E N D M E N T ==========

Remove line(s) 8 and insert:

providing an effective date.

000000

A bill to be entitled

An act relating to developmental disabilities; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to develop a waiver program to serve children and adults with specified disorders; requiring the agency to seek federal approval and implement the approved waiver in the General Appropriations Act; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (51) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed

to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based

on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(51) The agency shall work with the Agency for Persons with Disabilities to develop a ~~model~~ home and community-based waiver to serve children and adults who are diagnosed with familial dysautonomia or Riley-Day syndrome caused by a mutation of the IKBKAP gene on chromosome 9. The agency shall seek federal waiver approval and implement the approved waiver ~~subject to the availability of funds and any limitations provided~~ in the General Appropriations Act. The agency may adopt rules to implement this waiver program.

Section 2. The sums of $171,840 from the General Revenue Fund and $246,160 from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing this act during the 2006-2007 fiscal year.

Section 3. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1273 Home Health Services
SPONSOR(S): Cusack
TIED BILLS: **IDEN./SIM. BILLS:** SB 1926

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee		DePalma	Walsh
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 1273 exempts entities providing personal care services through certified nursing assistants or home health aides from certain licensure requirements. The bill provides that such entities are required to register with the Agency for Health Care Administration.

The bill specifies that organizations providing personal care services must obtain and maintain liability insurance coverage and submit proof of coverage with an initial application for registration, and with each annual application for registration renewal.

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government --- The bill authorizes home health aides and certified nursing assistants to provide personal care services through unlicensed homemaker and companion service organizations.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Licensed Home Health Agencies

Part IV of chapter 400, F.S., governs home health agencies, which are defined in s. 400.462(8), F.S., as organizations providing home health services and staffing services. Home health agencies provide nursing care; physical, speech, occupational, respiratory and IV therapy; home health aide services; homemaker and companion services; home medical equipment; nutritional guidance; and medical social services in a patient's home or place of residence.

Home health agencies are licensed by the Agency for Health Care Administration (AHCA) for two-year periods. The initial application for licensure must include a listing of services to be provided, the number and discipline of professional staff to be employed, and proof of financial ability to operate, including submission of a balance sheet and income and expense statement for the first two years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses.[1]

Home health agencies also must obtain and maintain malpractice and liability insurance in an amount not less than $250,000 per claim, and must submit proof of coverage with an initial application for licensure and with each application for license renewal.[2]

In addition to these extensive licensure requirements, home health agencies are subject to periodic unannounced surveys, as determined by AHCA.[3]

A home health aide (HHA) or certified nursing assistant (CNA) employed by a home health agency is required to provide personal care services assigned by and under the supervision of a registered nurse.[4] A home health agency is required to maintain a copy of the State of Florida certification for each CNA it employs, and documentation that each HHA it employs has successfully completed at least 40 hours of training in certain specified subject areas.[5]

The "assistance with activities of daily living" provided in a home health agency by a HHA or CNA includes assistance with ambulation, bathing, dressing, eating, personal hygiene, toileting, physical

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[1] S. 400.471(2), F.S.
[2] S. 400.471(6), F.S.
[3] Rule 59A-8.003, F.A.C.; survey frequency is determined by the extent of compliance with administrative rules and state laws observed in previous surveys.
[4] Rule 59A-8.0095, F.A.C.; pursuant to s. 400.487(3), F.S., a home health agency is required to arrange for supervisory visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction, approval, and agreement to pay the charge for the visits.
[5] Rule 59A-8.0095, F.A.C.

transfer, and self-administration of medication.[6] Other responsibilities of a HHA or CNA include the maintenance of a clean, safe and healthy living environment, performance of other activities as taught by a licensed health professional or contractor of the home health agency,[7] keeping records of personal health care activities, and observing appearance and gross behavioral changes in patients.

A HHA or CNA is authorized to supervise a patient's self-administration of medication in the home, but is limited to the following:[8]

- obtaining the medication container from the storage area for the patient;
- ensuring that the medication is prescribed for the patient;
- reminding the patient that it is time to take the medication as prescribed;
- preparing necessary items such as juice, water, cups, or spoons;
- opening and closing the medication container, or tearing the foil of prepackaged medications;
- steadying the patient's arm, hand, or other body parts;
- observing the patient self-administering the medication; and
- assisting the patient by placing unused doses of solid medication back into the medication container.

As of March 30, 2006, there are 1,473 licensed home health agencies in the state.[9] The Agency for Health Care Administration reports that telephone inquiries are received daily from individuals interested in starting new home health agencies.

Nurse Registries

Nurse registries arrange for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, and companions or homemakers --- acting as independent contractors --- to provide services to patients in their homes, and private duty and staffing services in health care facilities. A nurse registry is exempt from the licensing requirements of a home health agency, but must be licensed as a nurse registry, and licenses are issued for a two-year period.[10]

AHCA is authorized to inspect and investigate nurse registries pursuant to a complaint, and to determine the state of compliance with Part IV of chapter 400 and other applicable rules.[11] Unlike home health agencies, licensed nurse registries are not required to obtain insurance coverage as a condition of licensure.

A HHA or CNA may be referred by a nurse registry for a contract to provide care to a patient in his or her home only if that patient is under a physician's care, and a HHA or CNA referred for contract in a private residence shall be limited to assisting a patient with "bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself were he or she physically capable." A HHA or CNA is prohibited from providing medical or other health care services requiring specialized training and that may be performed only by licensed health care professionals, and a nurse registry is required to obtain the name and address of the attending physician and send written notification to the physician within 48 hours after a contract is concluded that a HHA or CNA will be providing care for that patient. Also, when a HHA or CNA is referred to a

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[6] *Ibid.*

[7] Per Rule 59A-8.0095, F.A.C., such activities must be patient-specific, and are restricted to: assisting with the change of a colostomy bag and reinforcement of dressing; assisting with the use of devices for aid to daily living, such as a wheelchair or walker; assisting with prescribed range of motion exercises; assisting with prescribed ice cap or collar; doing simple urine tests for sugar, acetone or albumin; measuring and preparing special diets; measuring intake and output of fluids; and measuring temperature, pulse, respiration or blood pressure.

[8] *Ibid.*

[9] According to the Agency for Health Care Administration, there were 350 complaints pertaining to home health agencies received by the agency in 2005.

[10] S. 400.506, F.S.

[11] *Ibid.*

patient's home by a nurse registry, the nurse registry is required to advise the patient, the patient's family, or any other person acting on behalf of the patient at the time the contract for services is made that registered nurses are available to make visits to the patient's home for an additional cost.[12]

A HHA or CNA referred for contract by a nurse registry shall:[13]

- be limited to assisting a patient in accordance with s. 400.506(10)(b), F.S.;
- be responsible for documenting services provided to the patient or client, and for filing said documentation with the nurse registry on a regular basis;
- be responsible for observing appearance and gross behavioral changes in the patient, and reporting these changes to the caregiver and the nurse registry or the registered nurse responsible for assessing the case when giving care in the home or to the responsible facility employee if staffing in a facility;
- be responsible to maintain a clean, safe and healthy living environment, which may include light cleaning and straightening of the bathroom, straightening the sleeping and living areas, washing the patient's dishes and laundry, and such tasks to maintain cleanliness and safety for the patient; and
- perform other activities as taught and documented by a registered nurse.[14]

Nowhere in either the Florida Statutes or Florida Administrative Code is explicit reference made to the ability of a HHA or CNA working for a nurse registry to assist in the patient's self-administration of medication. A home health agency is required to maintain a copy of the State of Florida certification for each CNA it employs, and documentation that each HHA it employs has successfully completed at least 40 hours of training in certain specified subject areas.[15]

Section 400.506(11), F.S., provides that providing services beyond the scope authorized in s. 400.506, F.S., constitutes the unauthorized practice of medicine or a violation of the Nurse Practice Act, and is punishable as provided under chapter 458, 459, or part I of chapter 464, F.S.

As of March 30, 2006, there are 230 licensed nurse registries in the state.[16]

Home Health Aides and Certified Nursing Assistants

Pursuant to s. 400.464(5)(d), both a home health aide and a certified nursing assistant --- acting in his or her individual capacity within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes --- are exempt from agency licensure requirements.

Homemaker and Companion Services

A "companion" is defined as an individual who spends time with or cares for an elderly, handicapped, or convalescent individual and who accompanies such individual on trips and outings and may prepare and serve meals.[17] Similarly, a "homemaker" is a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities

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[12] *Ibid.*
[13] Rule 59A-18.0081, F.A.C.
[14] Per Chapter 59A-18.0081, F.A.C., such activities must be patient-specific, and are restricted to: assisting with the change of a colostomy bag and reinforcement of dressing; assisting with the use of devices for aid to daily living, such as a wheelchair or walker; assisting with prescribed range of motion exercises; assisting with prescribed ice cap or collar; doing simple urine tests for sugar, acetone or albumin; measuring and preparing special diets; measuring intake and output of fluids; and measuring temperature, pulse, respiration or blood pressure.
[15] *Ibid.*
[16] AHCA reports that there were 32 complaints relating to nurse registries received by the agency in 2005.
[17] S. 400.462(7), F.S.

for an elderly, handicapped, or convalescent individual.[18] Neither a companion nor a homemaker is allowed to provide "hands-on" personal care services to a client.

Entities providing only homemaker and companion services to persons are not licensed by AHCA, but still are required to register with the agency for a one-year period.[19]

Duly-authorized officers or employees of AHCA have the right to make such inspections and investigations as are necessary in order to respond to complaints; however, the agency has no authority to inspect businesses prior to registration, or to survey them, absent receipt of a complaint, once they are registered.

On March 30, 2006, there were 999 organizations registered to provide homemaker and companion services in the state.[20]

AHCA has reported that homemaker and companion service chains and other businesses have sought to have personal care services added to the scope of service that their businesses can provide. "Personal care" is defined in s. 400.462(21), F.S., as assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule. Personal care is provided by home health aides and certified nursing assistants, and businesses providing personal care are to be licensed as home health agencies or nurse registries, unless exempt from licensing under s. 400.464(5), F.S.

In 1999, the Task Force on Home Health Services Licensure Provisions, established by the Legislature, reviewed information regarding programs in other states and found that 11 other states regulated personal care as a simpler form of licensing than Florida's home health agency and nurse registry licensing. The Task Force recommended in its report to the Legislature that personal care services be added to services authorized to be provided by homemakers and companions. However, the report noted that it was important that personnel providing personal care to be trained in lifting, transferring, and bathing disabled persons for the safety of the clients.

Unlicensed Activity

AHCA receives complaints of unlicensed home health activity throughout the state. In 2005, the agency received 20 complaints of unlicensed home health agencies, 3 complaints of unlicensed nurse registries, and 7 complaints relating to unregistered homemaker companion service providers. Although businesses determined to be providing services without a license or registration are given a notice of violation and are directed to obtain a license, many disregard the notices and continue operating. AHCA may seek an injunction under s. 400.515, F.S., only where there is an emergency affecting the immediate health and safety of a patient.

EFFECT OF PROPOSED CHANGES

HB 1273 amends s. 400.509, F.S., by exempting from licensure organizations providing personal care services through employed certified nursing assistants or through home health aides who are trained and qualified in providing personal care as determined by AHCA under s. 400.497(1), F.S. The bill specifies that the only home health services which may be provided are the bathing, dressing, toileting, grooming, eating, and physical transfer of a patient, as well as "those normal daily routines the patient could perform for himself or herself if he or she was physically capable. Organizations providing personal care services are required to register with AHCA.

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[18] S. 400.462(15), F.S.
[19] S. 400.509(1), F.S.
[20] AHCA reports that there were 58 complaints relating to organizations providing homemaker and companion services received by the agency in 2005.

The bill requires organizations providing personal care services to obtain and maintain liability insurance coverage as defined in s. 624.605(1)(b), F.S., in an amount not less than $250,000 per claim, and must further submit proof of liability insurance coverage with an initial application for registration and with each annual application for registration renewal.

Below is a table illustrating the licensure and registration requirements specific to licensed home health agencies, nurse registries, and unlicensed homemaker and companion service organizations under current law and proposed HB 1273:

	Home Health Agencies	Nurse Registries	Homemaker and Companion Service Organizations (under current law)	Homemaker and Companion Service Organizations (under HB 1273)
Is entity licensed?	Licensed (2 years)	Licensed (2 years)	No, registered (1 year).	No, registered (1 year).
Required background screening	Level 2 for administrator and financial officer.	Level 2 for managing employee and financial officer.	Level 1 for individuals having contact with clients; level 2 for managing employee and financial officer.	Level 1 for individuals having contact with clients; level 2 for managing employee and financial officer.
Authorized AHCA inspections and investigations	AHCA may perform unannounced surveys.	AHCA may inspect or investigate as necessary to respond to a complaint or determine compliance with laws/rules.	AHCA may inspect or investigate as necessary to respond to a complaint or determine compliance with laws/rules.	AHCA may inspect or investigate as necessary to respond to a complaint or determine compliance with laws/rules.
Insurance coverage required?	Yes; malpractice and liability insurance coverage in an amount of not less than $250,000 per claim.	No	No	Yes; liability insurance coverage in an amount of not less than $250,000 per claim.
Authorized to provide personal care services through HHA or CNA?	Yes, under the supervision of a registered nurse.	Yes, but only if a patient is under a physician's care.	No, personal care services cannot be provided by an organization providing homemaker and companion services.	Yes, a HHA or CNA may assist with "bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself if he or she were physically capable."
Responsibilities and duties of HHA and CNA	Performing personal care activities in a written assignment, maintaining a clean environment, keeping records of personal health care activities, observing patient appearance, performing other activities as taught by a licensed health professional employee or contractor of a home health agency, as specified in chapter 59A-8.0093, F.A.C.	Documenting services provided, observing patient appearance, maintaining a clean environment, performing other activities as taught and documented by a registered nurse, as specified in chapter 59A-18.0081, F.A.C.	N/A; personal care services cannot be provided by an organization providing homemaker and companion services.	Assisting a patient with "bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself if he or she were physically capable."
HHA/CNA assistance with administration or self-administration of medication	May obtain medication container, ensure medication is properly prescribed, remind patient it is time to take medication, and observe patient self-administer medication.	Unspecified.	N/A; personal care services cannot be provided by an organization providing homemaker and companion services.	Although not specifically indicated, the "normal daily routines the patient could perform for himself or herself" may be read to infer an ability to assist administration.

The bill provides an effective date of July 1, 2006.

C. SECTION DIRECTORY:

Section 1. Amends s. 400.509, F.S., exempting organizations providing personal care services to patients from certain licensure requirements; providing a description of the home health services which may be performed by an organization providing personal care services; requiring an organization providing personal care services to register with the Agency for Health Care Administration; requiring an organization providing personal care services to obtain and maintain liability insurance coverage, and to submit proof of liability insurance coverage with an initial application for registration and with each annual application for registration renewal.

Section 2. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See "Fiscal Comments", below.

2. Expenditures:

   See "Fiscal Comments", below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See "Fiscal Comments", below.

D. FISCAL COMMENTS:

Although it is staff's understanding that the bill will have some fiscal impact on the Agency for Health Care Administration, the agency had not provided fiscal commentary or legislative analysis outlining the bill's impact as of publication.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Although rulemaking authority is not provided in the legislation, s. 400.509, F.S., provides AHCA with rulemaking authority to administer the registration of homemaker and companion service organizations.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

A bill to be entitled

An act relating to home health services; amending s. 400.509, F.S.; exempting organizations that provide certain personal care services from licensure; requiring organizations that provide personal care services to register with the Agency for Health Care Administration and to maintain certain liability insurance coverage; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (1) of section 400.509, Florida Statutes, is amended to read:

400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants; liability insurance.--

(1)(a) Any organization that provides companion services or homemaker services, or that provides personal care services through employed certified nursing assistants under part II of chapter 464 or through employees who are trained and qualified in providing personal care as determined by the agency under s. 400.497(1), and does not provide a home health service other than assisting a patient with bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself if he or she was physically capable ~~to a person~~ is exempt from licensure under this part. However, any organization that

provides companion services, ~~or~~ homemaker services, or personal care services must register with the agency.

(b) Any organization that provides personal care services must obtain and maintain liability insurance coverage as defined in s. 624.605(1)(b) in an amount of not less than $250,000 per claim and must submit proof of liability insurance coverage with an initial application for registration and with each annual application for registration renewal.

Section 2. This act shall take effect July 1, 2006.